MassHealth

Commonwealth of Massachusetts
Executive Office of Health and Human Services

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Request and Justification for Therapy Services

Complete and attach this form when submitting a prior authorization request for physical, occupational, or speech/language therapy on paper or using MassHealth's Provider Online Service Center (POSC). If submitting a request through the POSC, providers can download the form from the POSC or complete the form online and submit it electronically as part of the request.

I. Provider information

Provider name _____ Group provider ID/SL _____

Provider address _____

Provider telephone no. _____ Individual provider ID/SL _____

II. Member information

Last name _____ First name _____ MI _____

MassHealth member ID no. _____

III. Other insurance information

MassHealth is the payer of last resort. The provider must use diligent efforts to verify whether other insurance exists and to obtain payment first from the other insurance.

Other insurance carrier _____ Policyholder's name _____

Policy no. _____

Has the insurance carrier changed since the last prior-authorization request? ☐ yes ☐ no

Why is the requested service not covered by this insurance? _____

_____

IV. Physician referral

Referring physician _____ Address _____

Primary medical diagnosis name and ICD-CM diagnosis code _____

Secondary medical diagnosis name and ICD-CM diagnosis code _____

Date of onset _____ Date of referral _____ Precautions _____

Reason for referral _____

V. Health-related services currently provided to the member

Check all services currently used by member. Indicate the frequency and payer.

Service	Frequency and payer
☐ Adult day health	
☐ Chapter 766/School-based Medicaid	
☐ Day habilitation	
☐ Early intervention services	
☐ Home health aide	
☐ Hospice	
☐ Nursing services	
☐ Occupational therapy	
☐ Personal care attendant	
☐ Physical therapy	
☐ Speech/language therapy	
☐ Other (specify) _____	

VI. Requested services

Location of service delivery ☐ home ☐ outpatient hospital department ☐ physician's office ☐ rehabilitation center ☐ therapist's office ☐ other (specify) _____

Date of initial evaluation _____ Rehabilitation potential _____

Has (or will) the member use all of the visits allowed without prior authorization as part of the current treatment plan? ☐ yes ☐ no

If yes, estimate the number of additional visits that will be needed to achieve treatment goals. _____

How do your goals differ from the other therapy services currently being provided? _____

_____

What other therapy services has the member received in the past 12 months? _____

_____

Who will be responsible for the carryover of the home exercise program, if applicable? _____

If other than the member, is this person able to attend therapy sessions on a regular basis to obtain training? ☐ yes ☐ no

If yes, has the member been compliant with the home exercise program to date? ☐ yes ☐ no

Please indicate the type, frequency, duration, and length of visit per day that you are requesting.

Type	Frequency per week (i.e., number of visits)	Estimated duration (i.e., weeks, months)	Length of visit per day
Physical therapy	_____	_____	_____
Occupational therapy	_____	_____	_____
Speech/language therapy	_____	_____	_____

VII. Medical necessity

Although most therapy can be viewed as beneficial, MassHealth does not pay for therapy services unless they are medically necessary as specified in 130 CMR 450.204, and meet the applicable MassHealth Guidelines for Medical Necessity.* Providers should address how the services

- provide specific, effective, and reasonable treatment of the member's diagnosis and physical condition;
- are directly and specifically related to an active treatment regimen;
- are of a level of complexity and sophistication that the judgment, knowledge, and skills of a licensed therapist are required;
- can achieve a specific diagnosis-related goal; and
- are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity.

Provide a brief summary below of the medical necessity for the treatment you are proposing, including individual therapies and therapeutic activities. **This field must be completed.**

_____

_____

What are the objective measures you have used to chart progress toward the stated goals? **This field must be completed.**

_____

_____

_____

_____

_____

Important: You must attach a copy of the current physician's referral for all requests in addition to completing this section. For first requests, you must also attach a copy of your initial evaluation. For subsequent requests, you must also attach a copy of the last two evaluations.

* Please refer to the MassHealth *Guidelines for Medical Necessity Determination for Physical Therapy*; the MassHealth *Guidelines for Medical Necessity Determination for Occupational Therapy*; or the MassHealth *Guidelines for Medical Necessity Determination for Speech and Language Therapy*, as applicable, for additional information. These MassHealth guidelines are located on the MassHealth website at www.mass.gov/masshealth/guidelines.

Signature

Therapist's name and title _____

Therapist's signature _____ Date _____

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